STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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April 5, 2010

Ms. Rita M. Landgraf, Cabinet Secretary
Department of Health & Social Services
1901 North Du Pont Highway
Administration Bldg., 1st Floor
New Castle, DE 19720

Dear Secretary Landgraf:

I write on behalf of the State Council for Persons with Disabilities (SCPD) as a follow-up to the JFC testimony regarding the Division of Substance Abuse and Mental Health's FY 11 budget provided by Mr. Brian Hartman on behalf of the Council and other organizations (attached). In summary, the councils recommended the establishment of a task force to analyze the current mental health system and develop a plan for shifting resources to a more balanced community based service delivery system. SCPD endorses such a task force similar to the one already created for the elderly and people with physical disabilities and referenced in Section 175 of the epilogue of the proposed budget bill.

Thank you for your consideration.

Sincerely,

Daniese McMullin-Powell, Chair
State Council for Persons with Disabilities

Cc: Mr. Brian Hartman, Esq.
Ms. Kevin Huckshorn
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

P&I/dhss mental health task force 4-10

MEMO

To: Joint Finance Committee
From: Brian Hartman, on behalf of the following organizations:

Disabilities Law Program
Developmental Disabilities Council
State Council for Persons with Disabilities

Subject: Division of Substance Abuse & Mental Health FY 11 Budget
Date: March 3, 2010

Please consider this memo a summary of the oral presentation of Brian J. Hartman, Esq. on behalf of the Disabilities Law Program ("DLP"), Developmental Disabilities Council ("DDC"), and the State Council for Persons with Disabilities ("SCPD"). We are addressing one (1) overarching aspect of DSAMH's budget, the skewing of resources to institutional versus community programs.

In Governor Markell's January State of the State address, he stressed the need for long-range budgetary planning. He commented as follows:

> While next year's budget requires our immediate attention, we must not govern only for the short term. We are here to make our State better for generations to come.

We view this emphasis on long-range planning as sound advice. Concomitantly, we encourage the JFC to consider the on-going fiscal imprudence of allocating a disproportionate amount of resources to an institutional setting. This is a chronic problem. In its 2007 report, the Governor's Task Force on DPC noted that "Delaware's rate of expenditures for community mental health services was only 45%, compared to the national average of 70%."[1] This distorted allocation of funding remains in effect today. The FY11 proposed budget allocates only 44% ($32.1 million) of the mental health budget to community support vs. 56% ($40.6 million) to DPC.[2] Of the 14,000+ clients served in DSAMH contract and state-operated programs, 56% of funds will be spent on an institution serving a few hundred individuals.

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[1]Governor's Task Force on the Delaware Psychiatric Center, Final Report (December 18, 2007) at 49-50. [Attachment "A"] The Task Force was co-chaired by the State's former budget director, Pete Ross, and the current DHSS Secretary, Rita Landgraf.

[2]The relevant excerpt from the proposed FY 11 budget bill (S.B. No. 196) is included as Attachment "B".

The most recent national statistics underscore the disparity. Last year the National Alliance on Mental Illness ("NAMI") issued a comprehensive report, "Grading the States 2009 Report Card". Delaware received a grade of "D" for community integration. Moreover, Delaware ranked 5th in the Nation in the number of psychiatric hospital beds per 1,000 adults with serious mental illness.[3]

The anomaly reinforced by the budget is that many Division clients unnecessarily spend years in DPC simply because there is a lack of funded community options. We understand that there may be more than 70 individuals at DPC who could be transitioned to the community if supervised or supported housing options were available. DPC "length of stay" statistics paint a compelling picture of Delawareans unnecessarily languishing in the Center. The Governor's Task Force report observed that "the average aggregate length of stay for residential adult patients at DPC in 2006 was 2,130 days (5.8 years) compared to the national average of 869 days (2.4 years).[4] This disparity has actually worsened since 2006. In 2009, the average length of stay for residential DPC patients was 2,682 days, i.e., 7.34 years! Federal SAMHSA statistics are corroborative. For DPC patients who reach the threshold of 1 year in the facility, the average length of stay is 3,379 days (9.25 years), almost double the national average.[5]

Recommendations

We recognize that major shifting of resources from institutional to community options cannot be achieved "overnight". We also recognize that the budget epilog continues to authorize the Department, with the approval of OMB and the Controller General, to reallocate some resources to the community.[6] However, statistically, progress towards shifting to a more community-based model is lagging. To "jump-start" the process, we recommend the establishment of a task force to analyze the current system and develop a "roadmap" for shifting to a more balanced mental health system. The Governor's proposed budget already creates such a task force for the aging and persons with physical disabilities with a report due by March 15,

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[3]Relevant excerpts from the report are included as Attachment "C".

[4]Governor's Task Force on the Delaware Psychiatric Center Final Report (December 18, 2007) at p. 49. [Attachment "A"]

[5]SAMHSA Delaware 2008 Mental Health National Outcome Measures, Table 2. [Attachment "D"]

[6]A copy of Section 155 of the epilogue of the proposed budget bill (S.B. No. 196) is included as Attachment "E".

2011.[7] The budget epilogue recites as follows:

> Recognizing that Delaware has an obligation to establish a rational long term care system to prevent expensive and premature institutionalization and to insure Delaware's senior and disabled population who are able to remain in their homes and communities should receive services needed to remain as independent as possible, it is the intent of the General Assembly that a Task Force shall be formed to develop ...[an analysis of innovations in other states, services needs, and recommendations].

Delaware enjoys a committed and progressive DHSS Secretary, DSAMH Director, and provider network. We need to take advantage of available mental health expertise to conduct the same planning being undertaken to balance the service delivery system for persons with physical disabilities.

Thank you for your consideration of our comments.

Attachments

F:pub/bjh/leg/mhbud11

[7]A copy of Section 175 of the budget epilog is included as Attachment "F".

EXCERPT

Governor's Task Force On the Delaware Psychiatric Center

Final Report

December 18, 2007

Task Force Members:

Senator Margaret Rose Henry
Kevin Ann Huckshorn, R.N.; MSN,
Rita Landgraf (Co-Chair)
Representative Pam Maier
Dennis Rochford
Harold Rosen, M.D.
Peter Ross (Co-Chair)
Yvonne Stringfield, Ed.D; R.N.
Gary Wirt, Ed.D

Created by:

Executive Order 100
August 17, 2007

Staff:
Brian Posey; AARP
Lisa Schieffert, DHSS
Keith Warren, Office of the Governor
Andrea Summers, Office of Highway Safety, Dept. of Safety and Homeland Security

Attachment "A"

- **The Task Force recommends that a utilization review (UR) process be initiated that is managed by an independent community contractor not otherwise involved in the DSAMH system of care.** This UR process should mirror the kind of UR performed by other community hospitals and managed care insurers and would provide the state with daily reports regarding people admitted to DPC who no longer meet criteria for this level of care. The above recommendations should alleviate this scenario and would afford the state a comprehensive planning process, which is cost-effective and ensures that the appropriate level of care is provided.

- **For DPC to better reflect their actual length of stay, data needs to be analyzed based by patient population inclusive of Forensic Unit (Mitchell), Long Term Care Unit (Carvel), Acute Care Unit (K-3) and Intermediate Care Units (K-S).** The average aggregate length of stay for resident adult patients at DPC in 2006 was 2,130 days compared to the national average of 869 days. CMHS reports that in 2006 Delaware's rate of expenditures for community mental health services was only 45%, compared to the national average of 70%.

III. Funding Considerations

A. National and Historical Perspective

As states steadily shift from a delivery system focused on inpatient services to one of community-based service, this movement has been reflected in their mental health budgets. A national study (NASMHPD Research Institute, 2005) shows dramatic changes in the allocation of total state mental health agency expenditures in the United States between 1993 and 2003. For example:

In 1993
--48% of mental health budget expenditures were allocated to state psychiatric hospital inpatient services
--49% of expenditures were allocated to community-based services

By 2002
--29% of expenditures were allocated to state psychiatric hospital inpatient services
--69% of expenditures were allocated to community-based services

Delaware's allocation of resources today is similar to that of the U.S. in 1993. In 2005, Delaware's spending on community-based services for the same time was 45%. It is difficult to know what Delaware's total community costs are as the state's Medicaid service costs are not included. It may be that with the addition of these Medicaid community mental health expenditures that DE's community funding is higher than 45%, which would change these ratios. Most states include Medicaid expenditures when reporting these costs.

- **The Task Force recommends that an explanation regarding why inpatient service costs are not being shared by Medicaid needs to be provided.** It should also be noted that the 45% of spending on community-based care includes funds to support the involuntary commitments to community psychiatric hospitals such as Rockford Center, Meadowwood and Dover Behavioral Health. The use of state general revenue funding for private psychiatric beds in the community needs to be reviewed. Medicaid generally pays the cost of psychiatric care when that care is provided in a general medical facility.

- **The Task Force recommends that all efforts need to be taken to access these federal dollars to help support these very expensive hospital beds.** Also, the actual per bed day costs need to be described in order to assure that the state is not over-paying for these beds. Costs per bed should reflect the costs paid by managed care providers for these same services for their covered populations.

B. Recent Delaware Budgetary Practices

- **The Task Force recommends that Delaware's budgetary allocations for community support services keep closer pace with the ongoing need, and that the community support service system receive inflationary increases to sustain their current level of services. The Task Force recommends a dedicated % of increase be provided to providers on an annual basis that is reflective of inflationary measures and/or the CPI. Between 2001 and 2007, private providers received less than 4% in contractual increases. During this same timeframe, the consumer price index increased by approximately 30%.** Rates for services, many of them set in 2001, have not be re-evaluated for increases. Providers have indicated this lack of increase has a direct impact on the delivery of service. Many have increased the number of individuals being served assigned to a staff member, resulting in a less intensive service for those with the most significant conditions. DE community mental health providers testified that they have not been able to provide cost of living increases for their employees for many years and that these same employees are still limited to mileage reimbursement that is almost 50% less than the federal rate. *Such erosion of community-based services can lead to increased use of unnecessary hospital care.* The non-state community providers have voiced that since 2001, community-based services have actually eroded. The Legislature last appropriated funds for group homes in the FY01 and FY02 budgets. Funds for supervised apartments were included in FY01, 02, 06, 07 and 08 budgets. As a result, *the Division's inventory of supported housing is limited to fourteen (14) group homes (serving 114 residents) and eight (8) supervised apartment programs. The combined capacity of the entire residential system is only two hundred nine (209) clients statewide.*

- **The Task Force supports the movement of the 35 patients to community-based services and the dedicated funding associated with this movement to adequately support those transitioning from DPC to community. This movement will bring the community residential placements to 244 and hospital census 210, if average**

(35-00-00) DEPARTMENT OF HEALTH AND SOCIAL SERVICES

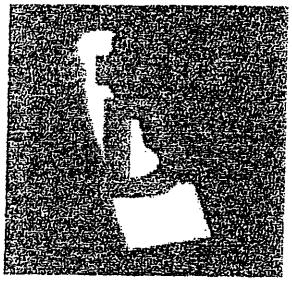
Personnel NSF	Personnel ASF	Personnel GF		$ Program ASF	$ Program GF	$ Line Item ASF	$ Line Item GF
			Children with Special Needs			45.0	
			Family Planning			325.0	
			Newborn			1,600.0	
			Indirect Costs			431.4	
			Child Health			1,437.3	
			Food Inspection			21.0	
			Food Permits			575.0	
			Medicaid Contractors/Lab Testing and Analysis			900.0	
			Water Operator Certification			22.0	
			IV Therapy			559.0	
			Health Statistics			1,200.0	
			Infant Mortality Task Force				27.0
			J-1 VISA			13.5	
			HFLC			30.0	
			Cancer Council				662.5
			Hospice			25.0	
			Health Disparities				50.6
			Debt Service				9.6
238.7	56.0	1,104.2	**TOTAL -- Public Health**			35,960.7	80,073.6
4.0	7.0	49.0	(-10) Director's Office/Support Services	1,601.6	3,294.6		
233.7	48.0	263.3	(-20) Community Health	32,326.3	26,195.2		
1.0		8.0	(-30) Emergency Medical Services	200.0	1,203.3		
	1.0	498.1	(-40) Delaware Hospital for the Chronically Ill	1,663.4	30,645.8		
		154.8	(-50) Emily Bissell	144.4	10,429.3		
		131.0	(-60) Governor Bacon	25.0	8,305.4		
238.7	56.0	1,104.2	TOTAL -- Internal Program Units	35,960.7	80,073.6		
			(35-06-00) Substance Abuse and Mental Health				
4.8	1.0	688.4	Personnel Costs			299.0	45,876.1
			Travel				6.9
			Contractual Services			1,569.9	28,465.9
			Energy				1,695.9
			Supplies and Materials			300.6	4,187.7
			Capital Outlay			9.0	184.0
			Tobacco Fund:				
			Contractual Services			142.2	
			Transitional Housing for Detoxification			177.1	
			Heroin Residential Program			412.0	
			Delaware School Study			28.7	
			Limen House			60.3	
			Other Items:				
	1.0		Medicare Part D			1,119.0	
			TEFRA			100.0	
			DPC Disproportionate Share			1,050.0	
			DPC Industries				38.1
			DOC Assessments			655.0	
			Clinical Care				277.5
			Kent/Sussex Detox Center			300.0	
			CMH Group Homes				6,901.3
			Debt Service				19.8
4.8	2.0	688.4	TOTAL -- Substance Abuse and Mental Health			6,222.8	87,653.2

(35-00-00) DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Personnel NSF	Personnel ASF	Personnel GF		$ Program ASF	$ Program GF	$ Line Item ASF	$ Line Item GF
3.0		62.0	(-10) Administration	60.0	3,834.4		
1.0		96.0	(-20) Community Mental Health	1,605.0	32,100.7		
0.8	1.0	504.4	(-30) Delaware Psychiatric Center	2,196.6	40,616.4		
	1.0	26.0	(-40) Substance Abuse	2,361.2	11,101.7		
4.8	2.0	688.4	TOTAL -- Internal Program Units	6,222.8	87,653.2		
			(35-07-00) Social Services				
199.5		192.2	Personnel Costs				10,595.5
			Travel				0.9
			Contractual Services				2,245.5
			Energy				86.8
			Supplies and Materials				88.5
			Capital Outlay				51.3
			Tobacco Fund:				
			SSI Supplement			1,240.4	
			Other Items:				
			Cost Recovery			75.1	
			General Assistance				4,547.5
			TANF Cash Assistance				10,187.5
			TANF Cash Assistance Pass Through			1,200.0	
			TANF General Fund				5,347.5
			Child Care				10,629.4
			Emergency Assistance				1,078.9
			Employment and Training				2,499.8
199.5		192.2	**TOTAL -- Social Services**			2,515.5	47,359.1
199.5		192.2	(-01) Social Services	2,515.5	47,359.1		
199.5		192.2	TOTAL -- Internal Program Unit	2,515.5	47,359.1		
			TOTAL--Temporary Assistance to Needy Families and Their Children (TANF) NSF appropriation				32,291.0
			(35-08-00) Visually Impaired				
25.2	3.0	36.8	Personnel Costs			105.9	2,627.2
			Travel				1.5
			Contractual Services			1.5	405.2
			Energy				81.1
			Supplies and Materials				67.0
			Capital Outlay			4.0	39.1
			Other Items:				
			BEP Unassigned Vending			175.0	
			BEP Independence			450.0	
			BEP Vending			425.0	
25.2	3.0	36.8	**TOTAL -- Visually Impaired**			1,161.4	3,221.1
25.2	3.0	36.8	(-01) Visually Impaired Services	1,161.4	3,221.1		
25.2	3.0	36.8	TOTAL -- Internal Program Unit	1,161.4	3,221.1		
			(35-09-00) Long Term Care Residents Protection				
16.2		36.8	Personnel Costs				2,283.0
			Travel				0.3
			Contractual Services				122.4
			Energy				9.1
			Supplies and Materials				5.9
			Capital Outlay				16.3
16.2		36.8	**TOTAL -- Long Term Care Residents Protection**				2,437.0

the States 2009

EXCERPT



Grading the States 2009 Report Card: Delaware

Mike F

In 2006, Delaware's mental health care system received a grade of C. Three years later the grade has dropped to a D, in part because of the lack of consumer-run programs and limited efforts to reduce the criminalization of people with mental illness. Full narrative (PDF).

Grades by Category (PDF) Detailed Score Card

I. **Health Promotion and Measurement: D** 25% of Total
Grade
Basic measures, such as the number of programs delivering evidence-based practices, emergency room wait-times, and the quantity of psychiatric beds by setting.

II. **Financing & Core Treatment/Recovery Services: D** 45% of Total
Grade
A variety of financing measures, such as whether Medicaid reimburses providers for all, or part of evidence-based practices; and more.

III. **Consumer & Family Empowerment: F** 15% of Total
Grade
Includes measures such as consumer and family access to essential information from the state, promotion of consumer-run programs, and family and peer education and support.

IV. **Community Integration and Social Inclusion: D** 15% of Total
Grade
Includes activities that require collaboration among state mental health agencies and other state agencies and systems.

Const

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Innovations

- New state leadership
- Mobile crisis intervention teams
- Integrated dual diagnosis treatment

Urgent Needs

- Implement state hospital investigation recommendations
- Supportive housing
- Consumer-run programs
- Jail and prison reentry programs and CIT

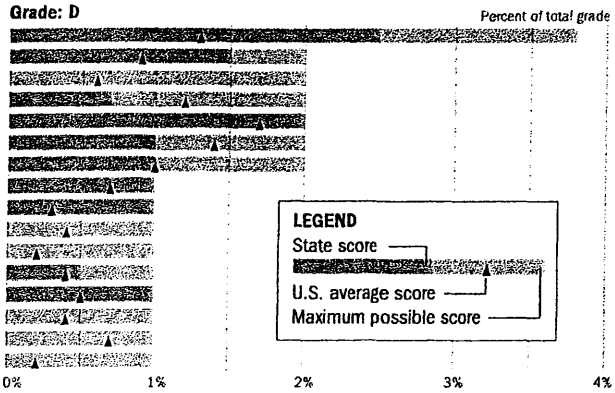
Additional Information and Resources

Attachment "C"

NAMI Score Card: DELAWARE — Grade: D

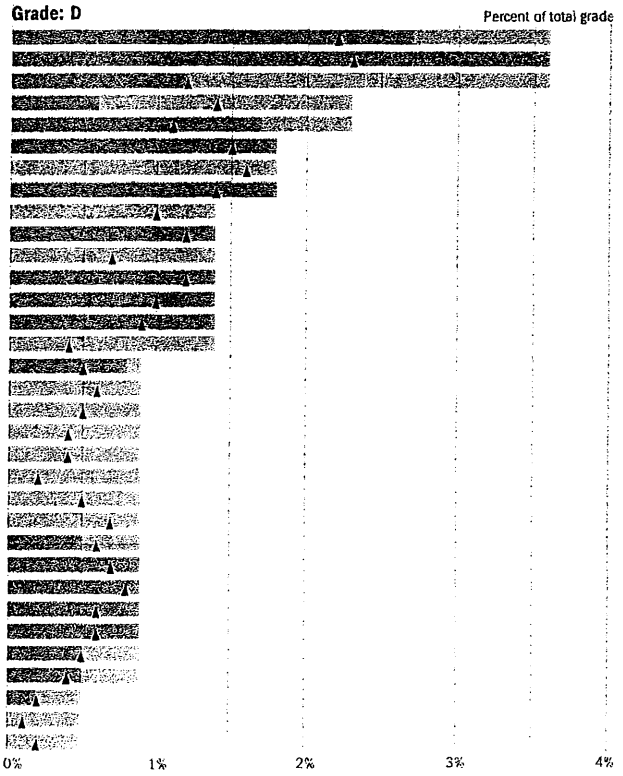
Category I: Health Promotion & Measurement — Grade: D

Workforce Development Plan
State Mental Health Insurance Parity Law
Mental Health Coverage in Programs for Uninsured
Quality of Evidence-Based Practices Data
Quality of Race/Ethnicity Data
Have Data on Psychiatric Beds by Setting
Integrate Mental and Primary Health Care
Joint Commission Hospital Accreditation
Have Data on ER Wait-times for Admission
Reductions in Use of Seclusion & Restraint
Public Reporting of Seclusion & Restraint Data
Wellness Promotion/Mortality Reduction Plan
State Studies Cause of Death
Performance Measure for Suicide Prevention
Smoking Cessation Programs
Workforce Development Plan - Diversity Components



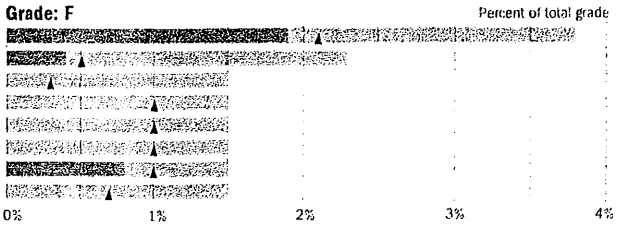
Category II: Financing & Core Treatment/Recovery Services — Grade: D

Workforce Availability
Inpatient Psychiatric Bed Capacity
Cultural Competence - Overall Score
Share of Adults with Serious Mental Illness Served
Assertive Community Treatment (ACT) - per capita
ACT (Medicaid pays part/all)
Targeted Case Management (Medicaid pays)
Medicaid Outpatient Co-pays
Mobile Crisis Services (Medicaid pays)
Transportation (Medicaid pays)
Peer Specialist (Medicaid pays)
State Pays for Benzodiazepines
No Cap on Monthly Medicaid Prescriptions
ACT (availability)
Certified Clubhouse (availability)
State Supports Co-occurring Disorders Treatment
Illness Self Management & Recovery (Medicaid pays)
Family Psychoeducation (Medicaid pays)
Supported Housing (Medicaid pays part)
Supported Employment (Medicaid pays part)
Supported Education (Medicaid pays part)
Language Interpretation/Translation (Medicaid pays)
Telemedicine (Medicaid pays)
Access to Antipsychotic Medications
Clinically-Informed Prescriber Feedback System
Same-Day Billing for Mental Health & Primary Care
Supported Employment (availability)
Integrated Dual Diagnosis Treatment (availability)
Permanent Supported Housing (availability)
Housing First (availability)
Illness Self Management & Recovery (availability)
Family Psychoeducation (availability)
Services for National Guard Members/Families



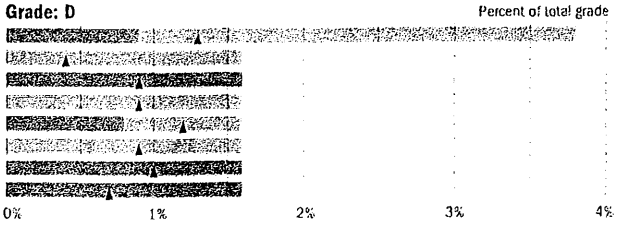
Category III: Consumer & Family Empowerment — Grade: F

Consumer & Family Test Drive (CFTD)
Consumer & Family Monitoring Teams
Consumer/Family on State Pharmacy (P&T) Committee
Consumer-Run Programs (availability)
Promote Peer-Run Services
State Supports Family Education Programs
State Supports Peer Education Programs
State Supports Provider Education Programs



Category IV: Community Integration & Social Inclusion — Grade: D

Housing - Overall Score
Suspend/Restore Medicaid Post-Incarceration
Jail Diversion Programs (availability)
Reentry Programs (availability)
Mental Illness Public Education Efforts
State Supports Police Crisis Intervention Teams (CIT)
Mental Health Courts - Overall Score
Mental Health Courts - per capita



On the inpatient side, NAMI's review of data on psychiatric beds from the American Hospital Association's annual survey reveals that there are about 113,988 psychiatric beds for adults across the country (see Table 3.3).[24] This is down from an estimated 126,849 beds in 2000, and 197,139 beds in 1990.[25]

Looking at the availability of beds per capita, there are 10.8 beds per 1,000 adults with serious mental illness. Across states this ranges from more than 15 beds per 1,000 adults with serious mental illness (in DC, New Jersey, Mississippi, New York, Delaware, and Nebraska) to fewer than eight (in Arizona, Florida, Rhode Island, Michigan, Nevada, South Carolina, Montana, and Ohio).[26]

As with ACT, there is little consensus on the minimum number of psychiatric inpatient beds communities should have available. One recent study suggests a minimum of 50 public psychiatric beds per 100,000 residents (which translates into roughly 9.3 beds per 1,000 adults with serious mental illness).[27] But even this suggested minimum threshold assumes that effective community-based services and assisted outpatient treatment programs are available, which is not the case.

Furthermore, NAMI's estimates include private psychiatric hospital beds (about 16 percent of the total) and forensic beds (i.e., beds for individuals who are awaiting trial, determined by the court to be incompetent to proceed to trial, or who are found not guilty by reason of insanity). In some states, such as California, the vast majority of state public psychiatric beds are forensic beds, meaning very few "civil" beds are available.

States must have an adequate mental health workforce to deliver critical services. Analyses of the mental health workforce by the Sheps Center document significant shortages across the country: while only one in five counties (18 percent) has an unmet need for nonprescribers, nearly every county (96 percent) has an unmet need for prescribers. In examining and scoring workforce availability, NAMI ranked states according to the severity of their mental health workforce shortage and divided them into four equal groups (or quartiles). States with the highest shortages got the lowest score for "workforce availability" and vice versa. With 96 percent of all counties experiencing prescriber shortages, it is clear that even states in the top quartile for workforce availability are still experiencing shortages.[28]

Where can innovative practices be found?

- **Rhode Island** has expanded its ACT program with the addition of RI ACT II—a less resource-intensive model for individuals who do not need the full level of ACT services. **Ohio** funds a forensic Assertive Community Treatment (F-ACT) team that serves people with serious mental illness upon release from prison.
- The **Georgia** Crisis and Access Line (GCAL) is an innovative mechanism for tracking available psychiatric beds. A toll-free, 24/7 phone service staffed by licensed clinicians who can make appointments anywhere in the state, GCAL tracks (in real time) the state's psychiatric bed capacity and works with emergency departments across the state to ensure people in need have access to available beds.

Finding #3: States are Not Ensuring their Service Delivery is Culturally Competent

As noted in Chapter 1, research confirms that people from minority racial and ethnic communities have less access to mental health services, are less likely to receive these services, and often receive poor quality care in treatment.

[23] Arizona, Arkansas, Georgia, Iowa, Kentucky, Louisiana, Missouri, Nevada, New Mexico, Tennessee, Utah, Vermont, and Washington (fewer than three per thousand) and Alaska, Mississippi, Kansas, North Dakota, and Wyoming (no ACT or ACT teams reported).

[24] The AHA surveys all hospitals in the United States, and identifies these hospitals from multiple sources including state hospital associations, the Joint Commission, and the Centers for Medicare and Medicaid Services. Because their database includes information on the total number of staffed beds *even for hospitals that do not respond to their survey*, we are confident that the majority of the beds in state psychiatric hospitals are captured in their data. The data also include inpatient psychiatric beds in other state- and county-owned hospitals and non-profit and investor-owned community-based hospitals.

[25] None of these figures include beds in federal (VA and other) hospitals, of which there were about 4,700 in FY 2007. Estimates for 2000 and 1990 are from Table 19.2 in Ronald W. Manderscheid and Joyce T. Berry (eds.), *Mental Health, United States, 2004* (Rockville, MD: Substance Abuse and Mental Health Services Administration, DHHS Pub No. (SMA)-06-4195, 2006). Available at http://mentalhealth.samhsa.gov/publications/allpubs/sma06-4195/chp19table2.asp.

[26] For scoring purposes, NAMI looked at the distribution across all states of adult inpatient psychiatric beds (per 1,000 adults with serious mental illness) and divided states into four equal groups (or quartiles). States in the top-most quartile (with the most beds per capita) were: DC, New Jersey, Mississippi, New York, Delaware, Nebraska, Connecticut, Massachusetts, Wyoming, Missouri, South Dakota, Maryland, and North Dakota. States in the bottom-most quartile (with the fewest beds per capita) were: Colorado, Texas, Vermont, Oregon, Washington, Ohio, Montana, South Carolina, Nevada, Michigan, Rhode Island, Florida, and Arizona.

[27] E. Fuller Torrey et al., *The Shortage of Public Hospital Beds for Mentally Ill Persons* (Arlington, VA: Treatment Advocacy Center, 2008). This assumes an overall prevalence rate for serious mental illness of 5.4 percent.

[28] States with the most severe shortages are: Alabama, Arkansas, Idaho, Indiana, Iowa, Mississippi, Nebraska, Nevada, South Dakota, Texas, Utah, West Virginia, and Wyoming. States with the least severe shortages (relative to other states) are: California, Connecticut, DC, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont, and Virginia.

Table 3.3 Grading the States 2009: Inpatient Psychiatric Beds in US Hospitals in FY 2007 (1)

State	State & Local Psychiatric Hospital Beds	Other State & Local Government Hospital Beds	Non-Government & Not-for-Profit Hospital Beds	Non-Government & Investor Owned Hospital Beds
Total (All States)	53,857	8,078	34,133	17,920
District of Columbia (DC)	817	0	131	104
New Jersey	3,685	127	1,747	210
Mississippi	1,553	225	148	568
New York	6,071	1,628	3,547	407
Delaware	323	0	45	92
Nebraska	716	0	259	0
Connecticut	777	25	810	0
Massachusetts	897	247	1,300	598
Wyoming	166	31	0	86
Missouri	1,342	72	983	702
South Dakota	244	0	176	0
Maryland	1,230	0	1,157	25
North Dakota	140	0	150	34
Pennsylvania	2,214	0	2,785	971
Kansas	692	128	337	0
Virginia	1,593	132	516	860
Hawaii	202	28	151	0
Indiana	1,172	201	886	386
New Hampshire	224	0	182	84
Alabama	990	399	107	584
Minnesota	1,147	134	581	0
Louisiana	874	285	188	675
Wisconsin	1,225	0	813	0
Idaho	215	63	70	237
Oklahoma	450	77	653	402
Georgia	2,539	129	610	462
Illinois	1,830	56	1,892	649
Tennessee	972	59	678	857
West Virginia	240	26	404	147
Maine	152	0	359	0
Kentucky	535	32	695	463
Utah	449	114	80	140
North Carolina	1,611	382	770	413
New Mexico	357	10	10	302
Iowa	223	210	542	0
Alaska	80	12	49	74
Arkansas	202	26	481	348
California	4,885	1,521	2,070	1,815
Colorado	860	53	300	140
Texas	3,108	275	1,270	2,410
Vermont	54	0	137	0
Oregon	739	31	349	0
Washington	1,216	105	342	115
Ohio	1,420	134	1,560	206
Montana	214	0	92	0
South Carolina	506	179	191	444
Nevada	401	0	18	257
Michigan	625	101	1,625	307
Rhode Island	0	0	282	0
Florida	1,342	622	1,235	1,261
Arizona	338	199	370	85

Notes: (1) Excludes all children's hospitals. Data represent "staffed beds," beds regularly available (those set up and staffed for use) within the reporting period.
(2) Estimates developed by Charles E. Holzer, III, Ph.D. of the University of Texas Medical Branch and Hoang T. Nguyen, Ph.D. of LifeStat LLC (see http://psy.utmb.edu/).

Source: FY 2007 AHA Annual Survey Database. Health Forum, an American Hospital Association affiliate, 2008. Reported prepared by AHA Resource Center, November 2008.

All Non-Federal Hospital Beds	Number of Adults with Serious Mental Illness (SMI), FY 2007 (2)	Non-Federal Psych. Beds Per 1,000 Adults SMI	Non-Federal Psych. Beds Per 1,000 Adults SMI—Rank	Federal Government Hospital Beds	Federal & Non-Federal Hospital Beds
113,988	10,590,429	10.8		4,660	118,648
1,052	22,811	46.1	1	0	1,052
5,769	258,617	22.3	2	0	5,769
2,494	125,269	19.9	3	0	2,494
11,653	672,924	17.3	4	490	12,143
460	28,652	16.1	5	0	460
975	60,744	16.1	6	0	975
1,612	108,730	14.8	7	0	1,612
3,042	210,815	14.4	8	732	3,774
283	19,733	14.3	9	203	486
3,099	222,596	13.9	10	106	3,205
420	30,351	13.8	11	15	435
2,412	175,173	13.8	12	116	2,528
324	24,131	13.4	13	0	324
5,970	448,455	13.3	14	175	6,145
1,157	95,110	12.2	15	125	1,282
3,101	261,959	11.8	16	22	3,123
381	32,435	11.7	17	27	408
2,645	226,713	11.7	18	0	2,645
490	42,818	11.4	19	0	490
2,080	186,541	11.2	20	411	2,491
1,862	167,810	11.1	21	388	2,250
2,022	182,593	11.1	22	82	2,104
2,038	188,057	10.8	23	18	2,056
585	54,375	10.8	24	0	585
1,582	147,343	10.7	25	47	1,629
3,740	348,789	10.7	26	87	3,827
4,427	420,841	10.5	27	165	4,592
2,566	246,003	10.4	28	32	2,598
817	81,214	10.1	29	0	817
511	51,248	10.0	30	16	527
1,725	181,441	9.5	31	19	1,744
783	82,362	9.5	32	21	804
3,176	334,855	9.5	33	96	3,272
679	71,674	9.5	34	30	709
975	104,922	9.3	35	21	996
215	23,650	9.1	36	0	215
1,057	116,435	9.1	37	73	1,130
10,291	1,180,000	8.7	38	28	10,319
1,353	157,828	8.6	39	8	1,361
7,063	832,795	8.5	40	0	7,063
191	22,712	8.4	41	10	201
1,119	137,345	8.1	42	0	1,119
1,778	218,585	8.1	43	184	1,962
3,320	418,207	7.9	44	370	3,690
306	38,961	7.9	45	0	306
1,320	170,022	7.8	46	15	1,335
676	88,540	7.6	47	42	718
2,658	348,154	7.6	48	412	3,070
282	37,739	7.5	49	17	299
4,460	660,443	6.8	50	31	4,491
992	220,909	4.5	51	26	1,018

Delaware 2008 Mental Health National Outcome Measures (NOMS): CMHS Uniform Reporting System

Utilization Rates/Number of Consumers Served	U.S.	State	U.S. Rate	States
Penetration Rate per 1,000 population	6,332,983	10.80	20.69	58
Community Utilization per 1,000 population	5,639,738	9.37	19.15	56
State Hospital Utilization per 1,000 population	173,307	0.61	0.59	51
Other Psychiatric Inpatient Utilization per 1,000	383,904	1.34	1.51	40

Adult Employment Status	U.S.	State	U.S. Rate	States
Employment Status (percent in Labor Force)	679,084	34%	39%	56
Employment Status (percent with Employment Data)	679,084	24%	21%	56

Adult Consumer Survey measures	State	U.S. Rate	States
Positive About Outcomes	71%	72%	54

Child/Family Consumer Survey measures	State	U.S. Rate	States
Positive About Outcomes	82%	64%	54

Readmission Rates: (Civil "non-Forensic" clients)	U.S.	State	U.S. Rate	States
State Hospital Readmissions: 30 Days	13,771	10.5%	9.3%	48
State Hospital Readmissions: 180 Days	31,720	25.9%	21.3%	49
State Hospital Readmissions: 30 Days: Adults	12,519	10.5%	9.4%	47
State Hospital Readmissions: 180 Days: Adults	29,096	25.9%	21.8%	47
State Hospital Readmissions: 30 Days: Children	1,228	-	8.2%	38
State Hospital Readmissions: 180 Days: Children	2,568	-	17.1%	43

Living Situation	U.S.	State	U.S. Rate	States
Private Residence	3,666,906	88.8%	80.8%	52
Homeless/Shelter	133,656	0.5%	2.9%	50
Jail/Correctional Facility	90,587	1.5%	2.0%	49

Adult EBP Services	U.S.	State	U.S. Rate	States
Supported Housing	65,797	5.9%	3%	34
Supported Employment	40,387	4.4%	2%	41
Assertive Community Treatment	58,502	13.4%	2%	40
Family PsychoEducation	25,127	3.87%	2%	19
Dual Diagnosis Treatment	46,706	5.38%	4%	25
Illness Self Management	147,089	30.55%	9%	22
Medications Management	253,414	-	23%	17

Child/Adolescent EBP Services	U.S.	State	U.S. Rate	States
Therapeutic Foster Care	16,291	1.0%	2%	28
Multi Systemic Therapy	8,126	-	1%	21
Functional Family Therapy	7,027	-	2%	14

Change in Social Connectedness	State	U.S. Rate	States
Adult Improved Social Connectedness	78%	73%	51
Child/Family Improved Social Connectedness	-	86%	49

Attachment "D"

APPROPRIATENESS DOMAIN: TABLE 2: Length of Stay (LOS) in State Psychiatric Hospitals, Other Psychiatric Inpatient and Residential Treatment Centers, FY 2008

STATE: Delaware

State Hospitals	Average LOS (Days) Discharged Clients: State	Median LOS (Days) Discharged Clients: State	In Facility <1 Yr Average LOS: Resident Clients: State	In Facility <1 Yr Median LOS: Resident Clients: State	In Facility >1 Yr Average LOS: Resident Clients: State	In Facility >1 Yr Median LOS: Resident Clients: State	Average LOS (Days) Discharged Clients: U.S.	Median LOS (Days) Discharged Clients: U.S.	In Facility <1 Yr Average LOS: Resident Clients: U.S.	In Facility <1 Yr Median LOS: Resident Clients: U.S.	In Facility >1 Yr Average LOS: Resident Clients: U.S.	In Facility >1 Yr Median LOS: Resident Clients: U.S.	States Reporting
All Age Groups	-	-	-	-	-	-	125	40	61	53	1,088	749	5
Children	-	-	-	-	-	-	72	52	65	55	277	259	35
Adults	299	21	59	19	3,379	1,588	160	46	106	77	1,731	1,053	50
NA	-	-	-	-	-	-	17	3	13	14	40	30	1

Other Inpatient	Average LOS (Days) Discharged Clients: State	Median LOS (Days) Discharged Clients: State	In Facility <1 Yr Average LOS: Resident Clients: State	In Facility <1 Yr Median LOS: Resident Clients: State	In Facility >1 Yr Average LOS: Resident Clients: State	In Facility >1 Yr Median LOS: Resident Clients: State	Average LOS (Days) Discharged Clients: U.S.	Median LOS (Days) Discharged Clients: U.S.	In Facility <1 Yr Average LOS: Resident Clients: U.S.	In Facility <1 Yr Median LOS: Resident Clients: U.S.	In Facility >1 Yr Average LOS: Resident Clients: U.S.	In Facility >1 Yr Median LOS: Resident Clients: U.S.	States Reporting
All Age Groups	-	-	-	-	-	-	14	7	13	7	140	136	4
Children	9	7	9	7	-	-	12	8	23	19	352	366	24
Adults	6	6	6	6	373	373	47	9	32	26	432	406	33
NA	-	-	-	-	-	-	1	1	0	-	-	-	1

Residential Treatment Centers	Average LOS (Days) Discharged Clients: State	Median LOS (Days) Discharged Clients: State	In Facility <1 Yr Average LOS: Resident Clients: State	In Facility <1 Yr Median LOS: Resident Clients: State	In Facility >1 Yr Average LOS: Resident Clients: State	In Facility >1 Yr Median LOS: Resident Clients: State	Average LOS (Days) Discharged Clients: U.S.	Median LOS (Days) Discharged Clients: U.S.	In Facility <1 Yr Average LOS: Resident Clients: U.S.	In Facility <1 Yr Median LOS: Resident Clients: U.S.	In Facility >1 Yr Average LOS: Resident Clients: U.S.	In Facility >1 Yr Median LOS: Resident Clients: U.S.	States Reporting
All Age Groups	-	-	-	-	-	-	104	99	55	51	204	185	2
Children	197	175	175	172	484	472	171	144	126	119	468	500	28
Adults	1,018	687	160	123	1,505	966	300	201	94	83	802	666	19
NA	-	-	-	-	-	-	11	11	-	-	-	-	-

Note:

Resident clients are clients who were receiving services in inpatient settings at the end of the reporting period.

This table uses data from URS/DIG Table 6.

State Notes:

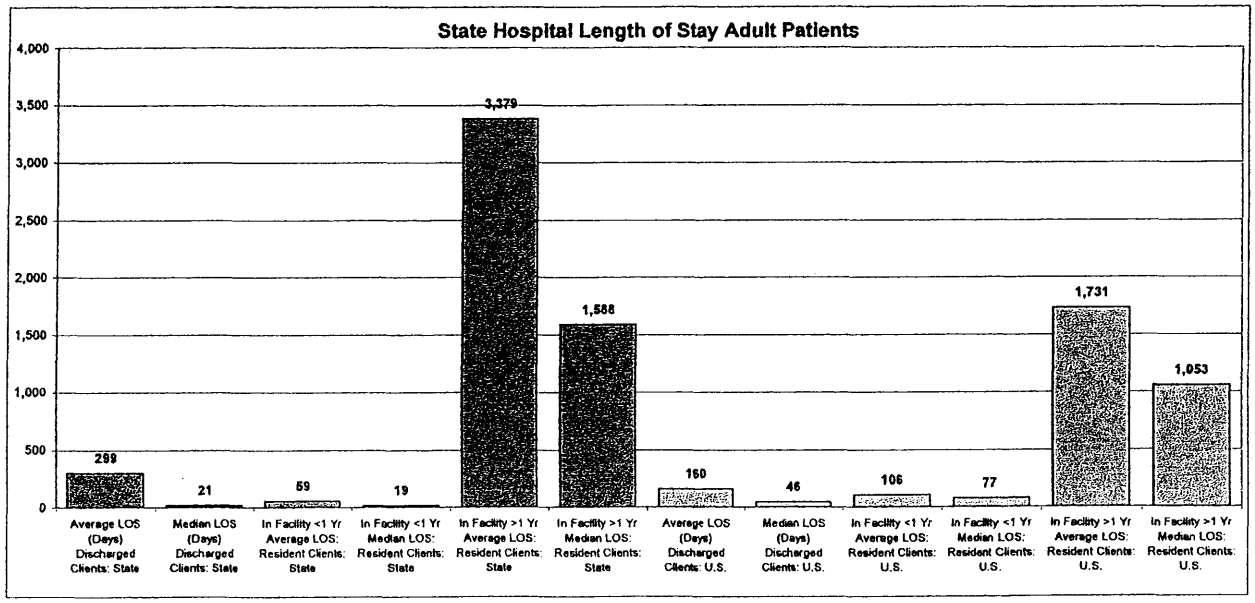
State Hospital None

Other Inpatient None

Residential Treatment Centers None

Community Programs None

Overall There is minor duplication between children and adult 18 year old consumers.



3) on-site training to teachers on appropriate teaching methods.

Section 155. The Department of Health and Social Services, Substance Abuse and Mental Health (35-06-00) is encouraged, where appropriate, to reallocate resources so as to create a balanced system of services and treatment among the Delaware Psychiatric Center (35-06-30), community hospitals, and community-based residential placements for persons with mental illness. Such reallocation initiatives must be made within the total division's appropriation limit with the approval of the Director of the Office of Management and Budget and the Controller General. These reallocation initiatives shall not compromise the standard of care of the remaining Delaware Psychiatric Center population.

Section 156. Section 1 of this Act provides an appropriation of $100.0 ASF to the Department of Health and Social Services, Substance Abuse and Mental Health, Community Mental Health (35-06-20). Substance Abuse and Mental Health expects to generate additional retroactive revenue as a result of the Tax Equity and Fiscal Responsibility Act (TEFRA) rebasing of Medicare payment rates at Delaware Psychiatric Center. These funds shall be used to fund the rebasing project and support the Division of Substance Abuse and Mental Health programs, including but not limited to purchasing medicines for clients.

Section 157. The Merit Rules notwithstanding, Department of Health and Social Services employees designated as Psychiatrists, as well as the Chief Psychiatrist in the Delaware Psychiatric Center (35-06-30) shall be eligible for standby pay and call back pay.

Section 158. Section 1 of this Act provides an appropriation of $1,200.0 ASF to the Department of Health and Social Services, Social Services (35-07-01) for TANF Cash Assistance Pass Through. The division shall be allowed to collect and deposit funds into this account as a result of child support payments collected by the Division of Child Support Enforcement on behalf of TANF clients. These funds will be used by the DSS to make supplemental payments to clients who are eligible to retain a portion of their child support under State and Federal TANF budgeting rules.

Section 159. Section 1 of this Act provides an appropriation to the Department of Health and Social Services, Substance Abuse and Mental Health, Delaware Psychiatric Center (35-06-30), for Contractual Services. Of that amount, $41.2 shall be made available for a Direct Patient Care Intern Program to enable direct care professionals to take courses to increase their skills in specialty areas.

additional services for adults with physical disabilities. Such services are not to exceed the estimated annualized revenue, and are subject to initial and on-going review by the Director of the Office of Management and Budget and the Controller General.

Section 174. Section 1 of this Act makes an appropriation to the Department of Health and Social Services, Services for Aging and Adults with Physical Disabilities (35-14-00) for Respite Care. Of that appropriation, $110.0 is appropriated to support families provided respite care services through the Caregiver Program.

Section 175. Recognizing Delaware has an obligation to establish a rational long term care system to prevent expensive and premature institutionalization and to insure Delaware's senior and disabled population who are able to remain in their homes and community should receive services needed to remain as independent as possible, it is the intent of the General Assembly that a Task Force shall be formed to develop the following:

(1) A summary analysis of all existing studies on the subject of long term care housing needs for Delaware's Aging and Disabled population;

(2) An analysis of programs and innovations in other states that have maximized consumer choice in the selection of a setting in which to receive long-term care services and supports and their ability to be replicated in Delaware;

(3) An analysis of service needs required for individuals to receive long term care in their homes and community, including an analysis of the supply of organizations providing services and existing or anticipated gaps in services required for home or community living;

(4) An analysis and recommended actions the State of Delaware should consider to increase consumer options and ability to choose and to support long term care housing needs for individuals, including affordable and accessible housing and home and community based service required by individuals who desire to receive long term care services in home and community;

(5) An analysis of publicly subsidized and other affordable housing options in Delaware and their role in providing home and community based services to older people and people with disabilities; and

(6) An analysis and recommended actions regarding projected demand for skilled nursing facility care.

The Task Force shall be chaired by the chair, vice-chair, or other committee member designated by the chair of the House Joint Finance Committee, and, in addition to its chair, that the chair appoint the following Task Force members:

(1) one member of the House Health and Human Development Committee;

(2) one member of the Housing and Community Affairs Committee;

(3) Delaware's Long Term Care Ombudsman;

(4) one representative of the American Hospital Association;

(5) one representative of the Delaware Healthcare Facilities Association;

(6) one representative of AARP;

(7) one representative of Delaware's physical disabilities community;

(8) one representative from Delaware Medicaid's Money Follows the Person leadership team;

(9) one representative from the Division of Aging and Adults with Physical Disabilities;

(10) one representative from the University of Delaware's Center for applied Demography and Survey Research;

(11) one professor of aging from an accredited Delaware University;

(12) one representative from a Delaware Home Health Agency;

(13) one representative from the Delaware Aging Network;

(14) one representative from the Delaware Nursing Home Quality Residents Assurance Commission;

(15) one member from the United Way of Delaware; and

(16) staff support will be available through AARP.

The Task Force will report on its findings to the General Assembly no later than March 15, 2011.